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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Refer to These Rotator Cuff Upgrade Strategies to Guarantee Your Claim's Success

Is your payer's advice lacking? Here's how to create internal guidelines for chronic/acute conditions.

Upgrading a rotator cuff strain to a torn rotator cuff can land your claim in troubled waters, especially as local carrier direction can be nonexistent. If your insurance adjuster lacks specific chronic/acute advice, create your own internal guidelines -- our experts show you how.

Scenario: Suppose a patient suffers a rotator cuff strain (840.4) while lifting boxes at work. The patient's workers' compensation carrier reimburses the practice for several months, after which the orthopedist decides that the patient requires surgery to repair what the physician determines is actually a partial torn rotator cuff (726.13). At this point, the workers' compensation insurer balks, stating that the claim will not be paid because it never authorized treatment for a partial torn rotator cuff. Can your practice upgrade a patient from an acute condition to a chronic one? Here's our experts' breakdown.

Diagnosis Upgrade Depends on Payer

With regard to rotator cuff tears, you should review the ICD-9 index. If you look up the main term "tear" and subterm "rotator cuff," your options are:

Tear

Rotator cuff (traumatic) 840.4
Current injury 840.4
Degenerative 726.10
Nontraumatic (complete) 727.61
Partial 726.13

In ICD-9, the inclusion notes for the codes for Sprains and Strains of Joints and Adjacent Muscles (840-848) state that these codes include the following types of injuries: avulsion, hemarthrosis, laceration, rupture, sprain, strain, tear. Therefore, you should report any traumatic injury to the cuff with code 840.4. A partial rotator cuff tear has its own distinct code (726.13).

In the example above, you have a dispute from workers' compensation, because the physician diagnosed the patient with a rotator cuff strain (840.4) and now determines that the patient has a partial torn rotator cuff (726.13). Your practice can't upgrade a condition without calling or getting authorization from the workers' compensation company, experts say. You or your doctor can ring the case manager or adjuster.

The U.S. Department of Labor (the workers' comp carrier for federal employees) requires any change to go through its claims adjuster. The adjuster has to authorize the new ICD-9 code and then notifies their outsourced claims procession company that the new code is good.

Changing the diagnosis really depends on the carrier, but this truly is the doctor's call, and ultimately, the insurance should recognize the change -- as long as it is related to the original injury, experts say.

What to say: Acute conditions, such as rotator cuff strains, are often treated conservatively and respond well with no further treatment. Sometimes, however, the conservative treatment fails, and the patient requires surgery after all, at which point the condition would be upgraded to a chronic one. This could take as long as a year.

List the patient's current condition -- the partial rotator cuff rupture (726.13) -- as the primary diagnosis. You should assign 905.7 (Late effect of sprain and strain without tendon injury) as the secondary code to help create a connection between the two conditions.

No Payer Advice? Create Internal Guidelines

Suppose your worker's compensation carrier doesn't have specific guidelines about chronic versus acute conditions and what to do when you need to upgrade.

Good idea: Many practices designate a three-month period for a condition to remain acute, after which it becomes chronic. This time period varies widely, however, with some practices allowing only a few days before "acute pain" turns chronic, while others give the patient six months or more.

Although CMS does not officially comment on how to differentiate between acute and chronic conditions, Medicare does define these terms in certain instances. For example, CMS defines a chronic wound as persisting for "longer than one month."

Action: Use your most common diagnoses as a basis for setting timeframes in your acute/chronic guidelines. How: Review your patient medical records to determine an average period when each type of injury heals or requires surgery. Create a list of those averages as a guideline.

Keep in mind: Even if your practice's policy is based on a three-month acute period, however, that won't necessarily be the case with every patient. Some patients may show marked improvement after three months, and the orthopedist will want to continue listing the condition as acute for three more months. Some patients' conditions will worsen after one month, causing an upgrade to "chronic." Time will not always be the deciding factor, says **Laureen Jandroep, CPC, CPC-H, CPC-I, CMSCS, CHCI,** CEO Certification Coaching Organization, LLC CodingCertification.Org, Egg Harbor City, NJ.

"I view it more as ongoing versus flare-up," Jandroep says. For instance, a patient might have carpal tunnel syndrome (354.0) for a year, but a sudden flare-up might cause such severe pain that a carpal tunnel release (64721, Neuroplasty and/or transposition; median nerve at carpal tunnel) is necessary. Note: ICD-9's official guidelines state, "If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indention level, code both and sequence the acute (subacute) code first."

According to Medline's medical encyclopedia, "Acute conditions are severe and sudden in onset" (e.g., a broken bone). "A chronic condition, by contrast, is a long developing syndrome, such as osteoporosis." It notes that osteoporosis (a chronic condition) may cause a broken bone (an acute condition). In this case, you would report both diagnoses, with the broken bone (733.1x) listed first, followed by the underlying disease (733.0x, which is the code for osteoporosis).

ICD-10: When your diagnosis system changes, you will use the following equivalents:

- 840.4 = S43.421A (Sprain of right rotator cuff capsule, initial encounter), S43.422A (Sprain of left rotator cuff capsule, initial encounter) or S43.429A (Sprain of unspecified rotator cuff capsule, initial encounter)
- 726.13 = M75.110 (Incomplete rotator cuff tear or rupture of unspecified shoulder, not specified as traumatic), M75.111 (Incomplete rotator cuff tear or rupture of right shoulder, not specified as traumatic), or M75.112 (Incomplete rotator cuff tear or rupture of left shoulder, not specified as traumatic)
- 905.7 = Specific codes from the "S" injury category of ICD-10, including (but not limited to) S43.401S (Unspecified sprain of right shoulder joint, sequela), S43.402S (Unspecified sprain of left shoulder joint, sequela), S43.409S (Unspecified sprain of unspecified shoulder joint, sequela), S43.491S (Other sprain of right shoulder joint, sequela), S43.492S (Other sprain of left shoulder joint, sequela), or S43.499S (Other sprain of unspecified shoulder joint, sequela).
- 354.0 = G56.00 (Carpal tunnel syndrome, unspecified upper limb), G56.01 (Carpal tunnel syndrome, right upper limb), or G56.02 (Carpal tunnel syndrome, left upper limb).

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